

§ 10.803

refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the appealed amount, OWCP shall initiate exclusion procedures as provided by § 10.815.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may make reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

§ 10.803 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

MEDICAL FEE SCHEDULE

§ 10.805 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services furnished by physicians, hospitals and other providers for work-related injuries shall not exceed a maximum allowable charge for such service as determined by the Director, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

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§ 10.806 How are the maximum fees defined?

For professional medical services, the Director shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a value to procedures identified by Health Care Financing Administration Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs; and a monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

§ 10.807 How are payments for particular services calculated?

Payment for a procedure identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the relative values for that procedure by the geographic indices for services in that area and by the dollar amount assigned to one unit in that category of service.

(a) The "locality" which serves as a basis for the determination of average cost is defined by the Bureau of Census Metropolitan Statistical Areas. The Director shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by the Health Care Financing Administration (HCFA).

(b) The Director shall assign the relative value units (RVUs) published by HCFA to all services for which HCFA has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, the Director may develop and assign any RVUs that he or she considers appropriate. The geographic adjustment factor shall be that designated by Geographic Practice Cost Indices for Metropolitan Statistical Areas as devised for HCFA and as updated or revised by HCFA from time to time. The Director will devise conversion factors for each

category of service, and in doing so may adapt HCFA conversion factors as appropriate using OWCP's processing experience and internal data.

(c) For example, if the unit values for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the dollar value assigned to one unit in that category of service (surgery) is \$61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding geographical indices for the locality times the conversion factor. If the geographic indices for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$$\begin{aligned} & [(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \\ & \times \$61.20 \\ & [2.45 + 3.44 + .56] \times \$61.20 \\ & 6.45 \times \$61.20 = \$394.74 \end{aligned}$$

§ 10.808 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, the Director may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for examinations performed under 5 U.S.C. 8123, and for other specially authorized services.

§ 10.809 How are payments for medicinal drugs determined?

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee.

(a) All prescription medications identified by National Drug Code (NDC) will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. The Director will establish the dispensing fee.

(b) The NDCs, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

§ 10.810 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Prospective Payment System (PPS) devised by HCFA (42 CFR parts 412, 413, 424, 485, and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All hospital discharges will be classified according to the DRGs prescribed by the HCFA in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by HCFA in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location (MSA) of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by HCFA to determine the specific rate for a hospital discharge under their PPS. The Director may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from HCFA's PPS on consideration of detailed medical reports and other evidence.

(4) The Director shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when he or she deems it necessary or appropriate.

(b) The Director shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when he or she deems it necessary or appropriate.